Medical Necessity Form for
Newly Approved Innovator Drugs

6101

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

- The provider may **call**: **1-866-684-4488**
  or the completed form may be **faxed** to:
  1-866-684-4477

- The patient may attach the completed form
  to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**
  or **email** the form only to:
  TPharmPA@express-scripts.com

Step 1

Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2

Please complete the clinical assessment:

1. What is the **indication or diagnosis**?		
2. Is there a **contraindication** to the use of another drug from the same drug class as the requested drug or to a drug that is used for the same indication?	☐ Yes Proceed to question 3	☐ No Proceed to question 4
3. What is the reason other drugs are contraindicated?	Proceed to question 4	
4. Has the patient **experienced significant adverse effects** with use of other drugs from the same drug class as the requested drug or with drugs that are used for the same indication?	☐ Yes Proceed to question 5	☐ No Proceed to question 6
5. What other drugs have been tried and what adverse effects did the patient experience?	Proceed to question 6	
6. Has the patient **experienced therapeutic failure** with use of other drugs from the same drug class as the requested drug or with drugs that are used for the same indication?	☐ Yes Proceed to question 7 on next page	☐ No Proceed to question 8 on next page

Continue to next page

7. What other drugs have been tried and what was the outcome with their use?	Proceed to question 8		
8. Is there an **alternative drug that could be used in this patient,** either from the same drug class as the requested drug or a drug that is used for the same indication?		☐ Yes Sign and date below	☐ No Proceed to question 9
9. What is the reason or explanation for stating there are no alternative drugs that could be used in this patient?	Sign and date below		

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____